Kansas State Board of Pharmacy
800 SW Jackson St. Ste 1414, Topeka, KS 66612-1244
Phone (785) 296-4056
Fax (785) 296-8420

CONSUMER COMPLAINT FORM

PLEASE PROVIDE ALL THE REQUESTED INFROMATION

Name of Person Registering Complaint:		Name of Patient:		
Address: Number and Street	City:	County:	State:	Zip Code:
Work telephone number:	Home telephone number:	Relationship to patient:		
Name of Pharmacy:				
Address of Pharmacy: Number and Street	City:	County:	State:	Zip Code:
Name of Pharmacist (if known):	Name of any other person involved:			
When did the problem occur?				

Details of Complaint

Describe the events in the order they happened, as simply as possible. (Use extra sheets if necessary.)

Have you discussed the matter with the pharmacist? ☐ Yes ☐ No

Name of person contacted:	Date of contact:

How was contact made? ☐ By phone ☐ By letter ☐ In person

Result of contact:

Further Information
(Complete only if applicable)

Prescribing doctor:	Telephone number:

Address of doctor: Number and Street	City:	State:	Zip Code:

Medication prescribed:	Medication received:	Prescription number:

The prescription was: ☐ for a new prescription ☐ a refill ☐ a new prescription for a medication taken or used previously

Was there harm to the patient? ☐ Yes ☐ No If yes describe briefly:

Did the pharmacist consult with you regarding your medication at the time it was dispensed?	☐ Yes	☐ No
Was any of the medication taken or used?	☐ Yes	☐ No
Do you still have the medication?	☐ Yes	☐ No
Do you still have container/label?	☐ Yes	☐ No

If you have the medication and/or container, please retain them until further notified by the board inspector.

If this complaint is against an individual licensed by the board of pharmacy, would you be willing to testify against the individual? ☐ Yes, I will be willing to testify. ☐ No, I would not be willing to testify.

IF APPLICABLE, PLEASE ATTACH TO THIS FORM <u>COPIES</u> OF ANY PAPERS INVOLVED (Prescription, bill/invoices received, cancelled checks, correspondence, ect.). DO NOT SEND ORIGINALS.

What outcome would you like to as a result of this complaint?

READ CAREFULLY AND SIGN BELOW:

The information contained in this form is true, correct and complete to the best of my knowledge.

_____ _____

Signature **Date**